LEGISLATIVE SERVICES AGENCY
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FISCAL IMPACT STATEMENT

LS 7470 **NOTE PREPARED:** Feb 25, 2005
BILL NUMBER: HB 1596 **BILL AMENDED:** Feb 22, 2005

SUBJECT: Emergency Department Payment.

FIRST AUTHOR: Rep. Brown T **BILL STATUS:** CR Adopted - 1st House
FIRST SPONSOR:

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
DEDICATED
X **FEDERAL**

Summary of Legislation: (Amended) This bill removes the Medicaid Risk-Based Managed Care Program exemption from the requirement that hospital emergency department care must be paid at a rate under the Medicaid fee structure.

Effective Date: (Amended) July 1, 2005.

Explanation of State Expenditures: (Revised) This bill would require the Medicaid managed care organizations (MCOs) to pay 100% of the Medicaid fee-for-service reimbursement rates for certain federally required screening exams provided by a physician in an emergency room whether or not those services meet the definition of what a prudent layperson would consider to be an emergency. Additionally, the bill would require that payment for physician services provided in the emergency department to an MCO-covered patient must be paid at 100% of the Medicaid fee structure. The bill would result in increased costs to the state to the extent that increased risk-based managed care costs would be passed through to the state in the negotiated capitated rates.

The Office of Medicaid Policy and Planning reports that the fiscal impact of this bill would be $12.6 M in total additional claims to the MCOs. The state impact would be $4.6 M. However, this estimate includes associated hospital outpatient claims which are not mentioned in the provisions of this bill. OMPP reports that within the PCCM program which is operated under the provisions of the existing statute, the physicians claims as well as the associated hospital emergency department claims are reimbursed.

This bill has two physician payment issues: first is the payment for the required screening exams. Medicaid

reports that the MCO's are required to pay for the screening exam performed on MCO recipients who present themselves at an emergency room. Physicians who are not contracted with the MCO, that is out-of network providers, must be paid at 100% of the Medicaid fee-for-service reimbursement. The MCOs may deny payment for subsequent inappropriate use of ER services after a medical record review. At least one of the MCO's is reported to pay all of the physician claims for screening fees if the doctor is contracted with the MCO; ER physician claims from non-contracted providers are subject to review. OMPP has estimated that the bill would require all the MCOs to pay for all screening or triage at 100% of the fee-for-service reimbursement for the physician and the hospital regardless of whether the patient believed there was an emergency condition or not. Financially, this requirement would impact the three MCOs differently depending the contracted status of the emergency department physicians, if the organization is currently paying triage fees to contracted providers or denying the claims in total. Additionally, there has been no information provided with regard to how the associated hospital emergency department claims are handled by each of the MCO's.

Medicaid managed care operates under a federally approved waiver. The rule waived is the recipient's freedom of choice. MCO recipients select or are assigned a primary care provider to give the individual a "medical care home . The primary care provider is then responsible for that recipient's preventative and routine care. Controlling the cost of inappropriate use of emergency room services is one of the methods that MCOs use to control costs within the network.

In FY 2002 the MCOs reported 13,006 non-contracted physician emergency claims denied. Total denied payment at 100% of Medicaid fee-for-service rates was $576,666. Legislative mandates requiring the participation in Medicaid managed care for certain recipients residing in the state's largest counties were estimated to result in increases in denied claims and associated payments of $959,073 in FY 2004 and $996,865 in FY 2005 if the relationship between inappropriate emergency room usage per member per month remained stable. Managed care enrollment in the state expanded at a greater rate than initially projected in 2003; if MCO enrollment in January 2005 is applied to this same analysis, the FY 2005 estimate would be increased to $1.4 M in total cost or approximately $532,000 in state General Funds. This information is presented to reference the range of the prior estimated impact on physician costs only. The MCO contracts and their network provider contracts have changed as well as the inclusion of another MCO to the available risk-based managed care providers.

Any denied payments occur within the capitated managed care contracts. The denial of payment does not represent a direct savings or cost to the state since the state pays a capitated amount for each MCO member month regardless of the cost incurred by the MCO for the member's care. The bill would result in increased costs to the state to the extent that the increased risk-based managed care costs would be passed through to the state in the negotiated rates. Rate adjustments generally occur in January. Any fiscal impact related to this bill would not be anticipated to result in higher capitated rates until 2006.

The second requirement is that the MCOs pay for physician services provided in emergency rooms at 100% of Medicaid fee-for-service reimbursement. This provision would preclude the MCOs from contracting for emergency room physician services at a rate lower than Medicaid fee-for-service in future contracts for their network providers unless such contracts specifically waived this provision.

Explanation of State Revenues: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program. Medicaid is a jointly funded state and federal program. Funding for direct services is reimbursed at approximately 62% by the federal government, while the state share is about 38%. Funding for administrative services is generally shared 50/50.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Family and Social Services Administration, Office of Medicaid Policy and Planning.

Local Agencies Affected:

Information Sources: Kristy Bredemeier, Acting Legislative Liaison, Office of Medicaid Policy and Planning, 317-233-2127.

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